STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155207	B. WING		09/10/2012
NAME OF I	PROVIDER OR SUPPLIE	D.	STREE	T ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	ROVIDER OR SUPPLIE.	ĸ	1201	DALY DR	
	VEN CARE & REH	IABILITATION CENTER	NEW	HAVEN, IN 46774	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
F0000	Complaint IN00 with Federal/sta F246, F282, and Survey dates: So 2012 Facility number Provider number AIM number: Survey team: Christine Fodres Julie Wagoner, Census bed type SNF/NF: Total: Census payor ty Medicare: Medicaid:	0114407- Substantiated at deficiencies cited	F0000	September 21, 2012 Brenda MeredithPublic Health Nurse SupervisorDivision of Long Te Care2 North Meridian St.Indianapolis, Indians 46204 Ms. Meredith, REQUE FOR DESK REVIEW OF THE FOLLOWING 2567 F246 F327Dear Brenda: Thank you taking the time to review our recently submitted 2567, from New Haven Care and Rehabilitation Center, New Haven, Indiana. I am requesti desk review compliance as I f that the citations were isolated events, with corrections immediately taken to correct those deficiencies. I do not believe that any residents' we affected by the deficiencies, validating my request for a de review. Staff was in serviced, re-educated to review call ligh placement, placement of water pitchers in resident's rooms, a following the plan of care regarding accurate assessme and documentation of hydratithroughout the facility, In-servicing occurred 09/15/12 and will continue thru 09/24/12 angure pursing staff were	est 282 u for eel d re sk and ut er und ent ion 2
	Other:	28		ensure nursing staff were	o of
	Total:	100		re-educated on the importanc these processesThe facility	е от
				takes pride in the fact that we	
	Sample:	5		represented very well during t	
	Sumpio.			survey process, and continue	
	These deficience	ies reflect state findings		be compliant in all other areas	s.An
	These deficienc	ics reflect state fillulings		auditing control system was p	ut

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155207 A. BUILDING B. WING				COMPLETED 09/10/2012		
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	cited in accordar	nce with 410 IAC 16.2.		into place for review of the deficiencies listed in the 2567 identify areas potentially at ris these types of findings. (hydration, call lights and propassessment and documentation I am pleased to announce that have maintained an excellent record in all areas and provide the highest quality of care. This evidenced by our yearly review with very low percentage of complaints related to our facility over the last several years. I would greatly appreciate your consideration into our request desk review of this 2567, audit being conducted will be availated for review if requested. Respectfully Submitted: Kris Schmitt R.N. / N. SNew Haven Care and Rehabilitation	to k for er on.) t we es s is ws, ty for ts ble		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FG4V11

Facility ID: 000114

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155207	B. WIN			09/10/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1201 D	ALY DR		
	VEN CARE & REH	ABILITATION CENTER			AVEN, IN 46774		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL					COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0246 SS=E	483.15(e)(1) REASONABLE A NEEDS/PREFER A resident has the services in the fact accommodations preferences, exces safety of the individual be endang Based on observe facility failed to within reach for #Q, Resident #R pitchers were with residents (Residents (Residents) and the residents. Findings included 1. During initial A.M., Resident # in her wheelchaither room door. It was observed accomposite side raid on 9-6-2012 at 1 was observed sith between beds, where the services is the services of the opposite side on the opposite side fails and the services where the services is the services of the services where the services is the services of the opposite side on the opposite side fails and the services where the services where the services is the services where	CCOMMODATION OF ENCES e right to reside and receive cility with reasonable of individual needs and ept when the health or ridual or other residents ered. ation and interview, the ensure call lights were three residents (Resident, Resident #S) and water thin reach for two ent #T, Resident #U) bservations of 7 : tour on 9-6-2012 at 10:00 eQ was observed sitting r, next to her bed towards Resident #Q's call light ross the bed on the	F02		This plan of correction is prepared and executed becau it is required by the provisions the state and federal law and recause New Haven Care and Rehabilitation agrees with the allegations and citations listed pages 1 through 20 of this statement of deficiencies. New Haven Care and Rehabilitation maintains that the alleged deficiencies do not jeopardize health and safety of the reside nor are they of such character as to constitute substandard quality of care or limit our capability to render adequate care. Please accept this plan correction as our credible allegation of compliance. F 246 483.15(e)(1) Reasonable accommodation of needs/preferences. a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?a) Resident's residin at New Haven Care and Rehabilitation have the potentic	of not do	09/25/2012
	light.				to be effected by the alleged deficient practice. Nursing sta were re-educated by the	ff	

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Event ID: FG4V11

Facility ID: 000114

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00 COMPLETED		
		155207	B. WIN			09/10/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			ALY DR	
NFW HA	VEN CARE & REH	ABILITATION CENTER			AVEN, IN 46774	
					7.17.2.11, 11.1.0.7.1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	DNS/ADNS on proper placeme	
		10:45 A.M., Resident #Q			of call lights and water pitchers	
	_	r room close to the end of			within residents reach. Educat	
		the door. Resident #Q's			to be completed by 09/24/12.	b)
		t observed on the side rail			How will other residents have	ing
		lent #Q indicated she			the potential to be effected b	
	could not find he	er call light when asked if			the same deficient practice b	
	she could put the	e call light on.			identified and what corrective	e
	<u> </u>	-			action(s) will be taken?b) Resident's residing at the cent	or
	On 9-10-2012 R	esident #Q's call light			have the potential to be effected	
	was in reach.				by the alleged deficient practic	
	was in reach.				DNS and nurse management	
	2. During initial tour on 9-6-2012 at 10:02				conducted facility rounds	
					9/10/2012 to identify other	
		R was observed sitting			residents who may potentially	
		veen the beds. Resident			effected by the alleged deficie	nt
	#R's call light w	as observed hanging on			practice. No other residents were found to be effected by the	20
	the wall behind l	her.			deficient practice during these	
					rounds. c) What Measures w	
	On 9-6-2012 at 1	1:31 P.M., Resident #R			be put into place or what	
	was observed in	bed with her eyes closed.			systemic changes will be	
		light was observed to be			made to assure the deficient	
		vall next to the call light			practice does not recur?c)	
	plate.	van next to the can right			DNS, ADNS, and nurse	
	piate.				management team (or assigned designee) will conduct facility	ea
	00.7.2012	10.45 A M. Davidana //D			rounds 4 times weekly to insur	re l
		10:45 A.M., Resident #R			that call lights/ water pitchers a	
		ting in her room next to			within residents' reach. These	• • • • • • • • • • • • • • • • • • •
		nt #R's call light was			audits will be reviewed monthly	y
		opposite side of the bed			through the PI committee for	
	attached to the s	ide rail. When asked if			further recommendations if	
	she could put he	r call light on, she			needed d) How will the corrective action(s) be	
	indicated she con	uldn't reach the call light.			monitored to insure the	
		_			deficient practice will not rec	ur.
	In an interview of	on 9-10-2012 at 8:19			i.e. what quality assurance	·
		or of Nursing Services			program will be put into plac	e
		vas no policy the call			and by what date will the	
	muicaicu ilicie v	vas no poncy me can				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	155207	A. BUILDING 09/10/2012			
		130207	B. WIN		A DDDDGG GITTY GT ATE TID GODE	03/10/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ALY DR	
NEW HA	VEN CARE & REHA	ABILITATION CENTER			ACT DIX AVEN, IN 46774	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
TAG		in reach, it was just		TAG	systemic changes be	DATE
	understood call lights should be in reach.				completed?(d) Nurse Managers	ers
					will conduct weekly audits to ensure call lights and water	
	_	tour on 9-6-2012 at 10:22			pitchers are within reach, for 4	
	· ·	S was observed sitting in			weeks, then bi-weekly for 4	
		t to the window. Her call			weeks, then monthly times 4 months to insure meeting	
		ed on top of the bedside			compliance. Audits will be	
	stand on the opp	osite side of the bed.			conducted on each shift for the first two months and random	
	On 9-6-2012 at 1	:34 P.M., Resident #S			checks thereafter on each	
	was observed in bed with her eyes closed.				shift.These audits will be	
	Resident #S's call light was observed to				reviewed monthly through the committee for further	PI
		bedside stand next to the			recommendations.	
	room curtain, aw					
	Ź					
	On 9-7-2012 at 1	0:48 A.M., Resident #S				
	was observed sit	ting in her wheelchair				
	between the beds	s. Resident #S's call light				
	was observed on	the bedside stand behind				
	her. When asked	if she could put her call				
	light on, Resider	nt #S replied she couldn't				
	reach the call lig	ht.				
	4. During initial	tour on 9-6-2012 at 10:28				
		T was sitting in his room				
		s, his water pitcher was				
		lside stand at the end of				
	his bed.					
	On 9-6-2012 at 1	:42 P.M., Resident #T				
		sting in bed. Resident				
		er was noted to be on top				
	of his bedside sta	and next to the window at				
	the bottom of the	e bed.				

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Facility ID: 000114

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155207	A. BUI. B. WIN	LDING		09/10/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		1201 DA			
NEW HA	VENICADE Ø DELL	ABILITATION CENTER			AVEN, IN 46774		
INEVV HA	VEN CARE & REH	ABILITATION CENTER		INEVV II	AVEN, IN 40774		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 9-7-2012 at 1	10:50 A.M., Resident #T					
	was observed sit	tting in his wheelchair					
		s. Resident #T's water					
		erved on top of his dresser					
	_	When asked if he could					
		oitcher if needed,					
	_	icated he could not as the					
	staff routinely pi	ut it in different places.					
	5. During initial tour on 9-6-2012 at 10:						
	32 A.M., Reside	ent #T was observed in					
	bed watching TV	V. Resident #T's water					
	pitcher was obse	erved on top of his dresser					
		at the foot of his bed.					
	ueross the room	at the foot of his oca.					
	On 0 6 2012 at 1	1:50 P.M., Resident #T					
		his bed watching TV.					
		ater pitcher was observed					
		op of his dresser across					
	the room at the f	foot of his bed.					
	On 9-7-2012 at 1	10:56 A.M., Resident #T					
	was observed in	bed watching TV.					
		ater pitcher was observed					
		tand sitting next to the					
		. When asked if he could					
	·	pitcher if needed,					
	Kesident #1 indi	icated he could not.					
		on 9-10-2012 at 8:19					
	A.M., the Direct	or of Nursing Services					
	indicated water	pitchers should have been					
	within reach.	_					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155207	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 09/10	LETED		
	PROVIDER OR SUPPLIER VEN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	A current policy titled "Hydration," dated 05-09, indicated the licensed nurse would ensure residents were offered fluids, but did not indicate water pitchers should be within reach. This Federal tag relates to Complaint IN00114407 3.1-3(v)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE S COMPLI		
		155207	B. WIN			09/10/	2012
	ROVIDER OR SUPPLIER	ABILITATION CENTER		1201 D	ADDRESS, CITY, STATE, ZIP CODE ALY DR AVEN, IN 46774		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL					COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services provide facility must be propersons in accord written plan of car Based on intervir facility failed to maintain hydratic reviewed for hydrogen sample of 5. (Re Findings include 1. Resident #O's 9-7-2012 at 2:00 diagnoses include to congestive heap ressure, and and Resident #O's No. 8-4-2012 at 12 n #O was having his Skin tenting and noted. A Nurse's Note, indicated Reside for loose stools mouth were not a service of the servic	UALIFIED PERSONS/PER vided or arranged by the rovided by qualified dance with each resident's re. ew and record review, the follow a care plan to on for 2 of 5 residents dration maintenance in a sident #O, Resident #P) : record was reviewed P.M. Resident #O's ed but were not limited art failure, high blood emia. urse's Notes, dated oon, indicated Resident syperactive bowel sounds. dry mouth were not dated 8-4-2012 at 8 P.M., nt #O was given lomotil Skin tenting and dry	F02		F282 483.20(k)(ii) Services B Qualified Persons/Per Care Plan a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?a) Resident residing at the center have the potential to be effected by the alleged deficient practice. Nursing staff were re-educated on proper documentation/Assessment of hydration. Intake of cc's for residents fluid consumption at meal times, and hydration pas times will be documented by nursing staff to reflect fluid consumption and follow reside plan of care. b) How will other residents having the potentiat to be effected by the same deficient practice be identified and what corrective action(s) will be taken?b) Resident's residing at the center have the potential to be effected by the alleged deficient practice. Nursing staff was re-educated proper documentation of fluid consumption by residents for	ed t's s nt's r il	09/25/2012
	indicated Reside	nt #O had continued to kin tenting and dry mouth			meals, and hydration passes to identify residents potentially at risk. Nursing also re-educated		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155207	1			09/10/2	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
N. (C.) A. () A. (VEN 0455 4 5511	ABII ITATION OFNITED			ALY DR		
NEW HA	VEN CARE & REH	ABILITATION CENTER		NEW H	AVEN, IN 46774		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	were not noted.				the DNS/ADNS/UM's on prope	er	
					documentation and assessme	nt	
	A current care plan, dated 6-9-2012, titled				of skin turgor, and mucous		
					membranes. Education to be		
	_	ydration included the			completed by 09/24/12 c) Wha		
		give medicines for			Measures will be put into pla		
	diarrhea per phy	sician's order, observe			or what systemic changes w		
	resident for sign	s and symptoms of			be made to assure the deficie	ent	
	dehydration such	n as tenting skin, dry			practice does not recur?c) Licensed Nursing staff will be		
	-	rt to physician if noted,			required to conduct hydration	ekin	
					checks weekly on residents to		
	observe for signs of pain, obtain lab work				ensure no s/s of dehydration a		
	per orders, record frequency and amount				present These checks will be		
	of diarrhea, and	encourage oral fluids.			tracked on the TAR. DNS,		
					ADNS, and nurse managers (or	
	A meal intake re	cord dated August 2012			assigned designee) will condu	ct	
	indicated on 8-4	-2012, Resident O's meal			hydration audits weekly to insu		
		a total of 720 milliliters			that proper hydration assessm		
		5-2012, her meal fluid			and care plan interventions are		
					documented These audits wi be reviewed monthly through t		
		al of 720 ml's. There was			PI committee for further	iie	
	no other docume	entation of fluid intake.			recommendations. d) How wil	.	
					the corrective action(s) be	•	
	A review of nurs	sing documentation did			monitored to insure the		
	not reveal an am	ount for diarrhea			deficient practice will not rec	ur,	
	recorded.				i.e. what quality assurance		
					program will be put into plac	e	
	In an intervious	on 0.7.2012 of 2:22 D.M.			and by what date will the		
		on 9-7-2012 at 2:33 P.M.,			systemic changes be		
		rector of Nursing			completed?(d)) Nurse		
	_	ans were initiated and			Managers will conduct weekly		
	interventions we	ere to be followed.			audits to ensure call lights and		
					water pitchers are within reach		
	2. Resident #P's	record was reviewed			for 4 weeks, then bi-weekly for weeks, then monthly times 4	4	
		27 A.M. Resident #P's			months to insure meeting		
		led but were not limited			compliance. Audits will be		
	•				conducted on each shift for the	e	
	l '	y disease, heart failure,			first two months and random		
	and high blood p	pressure.	1			l	

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PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155207	A. BUILDING B. WING	00 	COMPLETED 09/10/2012		
	PROVIDER OR SUPPLIER	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE		
	titled "Risk for final intake related to interventions of: regimen for treat give medication observe resident including skin te obtain lab work particularly and the strength of the strength	e's notes between 7-2012 revealed nurse's lude any reference to ry mouth. titled Care Plan, dated -8-2012, provided by the dicated care plans yes to meet resident needs		checks thereafter on each shif These audits will be reviewed monthly through the PI commi for further recommendations.			

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Facility ID: 000114

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155207	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY TPLETED 10/2012		
	ROVIDER OR SUPPLIER VEN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	3.1-35(g)(2)						

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Event ID: FG4V11

Facility ID: 000114

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155207	B. WIN			09/10/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALY DR		
NEW HA	VEN CARE & REHA	ABILITATION CENTER			AVEN, IN 46774		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0327 SS=D	483.25(j) SUFFICIENT FLU HYDRATION The facility must p sufficient fluid inta hydration and hea Based on intervite facility failed to a three of 5 resider hydration status of #O, Resident #P) Findings include 1. Resident #K's 9-6-2012 at 3:18 diagnoses includ to heart failure, b diabetes. Resident #K's lab indicated Resider nitrogen) was 26 Nurse's Notes of indicated Resider and at 8:45 P.M. A Nurse's Note of indicated the phy Resident #K and urinalysis and ch	JID TO MAINTAIN provide each resident with take to maintain proper alth. ew and record review, the assess hydration status of this reviewed for (Resident #K, Resident to in a sample of five.	F03		F327 483.20(j) Sufficient Fluid to meet Hydration a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a) Resident's residin at the center have the potential be effected by the alleged deficient practice. Nursing stawere re-educated by DNS/ADNS/UM's on proper documentation of hydration in cc's for residents at meal times and hydration pass times to reflect resident's fluid consumption and follow reside Plan of Care by 09/24/12. b) Hwill other residents having the potential to be effected by the same deficient practice be identified and what corrective action(s) will be taken?b) Resident's residing at the cent have the potential to be effected by the alleged deficient practice by the alleged deficient practice by the alleged deficient practice in the potential to be effected by the same deficient practice by the alleged deficient practice by the alleged deficient practice in the potential to be effected by the same deficient practice by the alleged deficient practice by the	ng Il to ff s, nt's low le e e e e e e e	DATE 09/25/2012
	further indicated lethargic.	Resident #K remained			proper documentation of skin assessments, skin turgor, and mucous membranes. to Identif	·y	

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
155		155207	A. BUII B. WIN			09/10/	2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
NEW HAVEN CARE & REHABILITATION CENTER				1201 DALY DR NEW HAVEN, IN 46774				
NEW DA	VEN CARE & RED	ABILITATION CENTER		INEVVI	IAVEN, IN 40774			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	The physician's progress note, dated				residents potentially at risk. c			
	1-16-2012, indi	cated Resident #K was		What Measures will be put into				
	not complaining	of any particular			place or what systemic			
		at he was tired and the			changes will be made to			
		of the was thed and the			assure the deficient practice	•		
	1 2	•			does not recur?c) Licensed	ło.		
	what was wrong				Nursing staff will be required to conduct hydration skin checks			
					weekly on residents to ensure			
	A Nurse's note of	on 1-17-2012 at 1:36			s/s of dehydration are presen			
	P.M., indicated	Resident #K was slightly			These checks will be tracked			
	lethargic and unable to feed himself. A Nurse's note on 1-18-2012 from 6-2:30				the TAR. DNS, ADNS, and n			
					managers (or assigned design	nee)		
	P.M., indicated Resident #K was tired and			will conduct hydration audits weekly to insure that proper				
	listless.							
	iistiess.				hydration assessment and ca	re		
					pla.n interventions are	II ha		
	A physician's progress note, dated				documented. These audits wi reviewed monthly through the			
	1-19-2012, indicated medications were				committee for further	; F1		
	reviewed, and R	esident #K was to return			recommendations. d) How wi	ill		
	to clinic in 4 mo	nths. There was no note			the corrective action(s) be			
		viewed restlessness or			monitored to insure the			
	fatigue.	viewed restressions of			deficient practice will not re-	cur,		
	latigue.				i.e. what quality assurance			
		1 . 11 10 0010 . 0			program will be put into place	ce		
		dated 1-19-2012 at 2			and by what date will the			
	P.M. indicated F	Resident #K was lethargic			systemic changes be			
	and confused. A	Nurse's Note dated		completed?(d) Nurse				
	1-20-2012 at 8:3	30 A.M. indicated		Managers/Designee wi		uct		
	Resident #K indicated he was very tired,			weekly audits during facilit rounds to ensure no s/s of				
	the Nurse Practitioner was notified and he			dehydration weekly, for 4 weeks,		ske		
				then bi-weekly for 4 weeks, then				
	was sent to the hospital.				monthly times 4 months to ins			
	A Nurse's progress note from the hospital on 1-20-2012 at 2:47 P.M., indicated				assessment of skin /mucous			
					membranes are conducted t	o		
					Identify residents potentially a	ıt		
	Resident #K's skin turgor was within				risk. These audits will be			
	normal limits.				reviewed monthly through the	· PI		
					committee for further			
			ı		recommendations		1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL		
		155207	B. WIN	G		09/10/	2012
NAME OF E	PROVIDER OR SUPPLIE	R	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF TROVIDER OR SOTTELER			1201 DA				
NEW HA	VEN CARE & REH	ABILITATION CENTER		NEW H	AVEN, IN 46774		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		nysician's note, dated					
		34 P.M., indicated					
		s admitted with mental					
		condary to infection,					
	1	d electrolyte imbalance,					
	•	ty of a new stroke could					
		. The note indicated BUN					
	on admission wa	as 43 (normal was 7-20)					
		as 1.8 (normal (0.7-1.5).					
	Antibiotics and	fluids were ordered.					
	A hospital labor	atory report, dated					
	1-21-2012 at 5:4	48 A.M., indicated					
	Resident #K's B	UN was 31 and creatinine					
	was 1.3.						
	There was no ca	re plan to indicate					
	Resident #K wa	s to be monitored for					
	hydration status.						
	There was no in	dication in the Nurse's					
	notes Resident #	K was assessed for					
	hydration status	after he became lethargic					
	and tired.						
	A Nursing chan	ge of condition document,					
	dated 1-20-2012	2, indicated Resident #K's					
	general appeara	nce was lethargic, but did					
	not indicate the status of Resident #K's						
	mucous membra	anes or skin turgor.					
	A Medical Nutrition Therapy Assessment,						
	dated 11-8-2011	, indicated Resident #K's					
fluid needs were 2040 milliliters per day.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155207			B. WIN			09/10/2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	
				1201 DA		
NEW HA	NEW HAVEN CARE & REHABILITATION CENTER			NEW H	AVEN, IN 46774	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG				PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	BEI ICIENCT)	DATE
	Maalintala flair	d managed and d Tanasana				
	Meal intake fluid records, dated January					
	· ·	Resident #K consumed				
	540- 1200 millil	iters per day.				
	A Madiantina A	durinistration Decemb				
		dministration Record,				
		012, indicated Resident				
		ed between 60 and 120				
		quid supplement per day;				
		f 600-1320 milliliters per				
	*	ke. There was no further				
	documentation of	of fluid intake.				
	In an internal	0 0 7 2012 -4 0.55				
		on 9-9-7-2012 at 9:55				
		or of Nursing indicated				
		always had fluids				
		ere was no tracking of the				
		Resident K took in				
	during the time l	ne was ill.				
	2 Dagidant #Ola	record was reviewed				
		P.M., Resident #O's				
	~	led but were not limited				
	_	art failure, high blood				
	pressure, and and	emia.				
	Resident #O's No	urse's Notes, dated				
		oon, indicated Resident				
	_	hyperactive bowel sounds.				
	Skin tenting and dry mouth were not					
	noted.					
	A Nursals Note	dated 8-4-2012 at 8 P.M.,				
		ent #O was given lomotil				
	mulcaled Reside	III TO was given follows	ı			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155207		B. WIN			09/10/2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	
NEW LAVEN CARE A RELIABILITATION CENTER				1201 DA		
NEW HAVEN CARE & REHABILITATION CENTER				NEW H	AVEN, IN 46774	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL DESCRIPTION OF LOCAL PROPERTY OF THE PROPERTY OF			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	Birtelikery	DATE
	for loose stools. Skin tenting and dry					
	mouth were not	noted.				
	A Nurgala Nota	on 8-5-2012 at 8 P.M.,				
		nt #O had continued to				
		kin tenting and dry mouth				
	were not noted.					
	A current core m	lan, dated 6-9-2012,				
	_	for dehydration" included				
		of: give medicines for				
		sician's order, observe				
		s and symptoms of				
	*	as tenting skin, dry				
		rt to physician if noted,				
	observe for signs of pain, obtain lab work					
		d frequency and amount				
	of diarrhea, and encourage oral fluids.					
	Δ meal intake re	cord, dated August 2012,				
		-2012, Resident O's meal				
		a total of 720 milliliters				
		5-2012, her meal fluid				
		of 720 ml's. There was				
		entation of fluid intake.				
	no other docume	munon or maid illuxe.				
	A review of nurs	sing documentation did				
		ount for diarrhea				
	recorded.	O WILL TO I WINITION				
	10001404.					
	3. Resident #P's record was reviewed 9-7-2012 at 11:27 A.M. Resident #P's					
		led but were not limited				
	to chronic kidney disease, heart failure,					

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ì '		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155207		A. BUILDING 00			COMPLETED 09/10/2012	
133207			B. WIN			09/10/2012
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STATE, ZIP CODE	
NEW HAVEN CARE & REHABILITATION CENTER				1201 DA	ALY DR AVEN, IN 46774	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE
	and high blood p	pressure.				
	_	lan, dated 8-10-2012,				
		luid output exceeding				
		diuretic use," included				
		follow therapeutic				
	•	ment of health condition,				
	~	as per physician's order,				
		for signs of dehydration				
	including skin tenting and dry mouth,					
	obtain lab work per physician orders.					
		tion Therapy Assessment,				
	dated 8-10-2012, indicated fluid needs for Resident #P were 2976-3720 milliliters per day.					
	A meal fluid inta	ake record indicated				
		a meal fluid intake of				
	960-1680 ml's.					
	A review of nurs	se's notes between				
	8-1-2012 and 9-7	7-2012 revealed nurse's				
	noted did not inc	clude any reference to				
	skin tenting or dry mouth.					
		titled hydration, dated				
	5-09, indicated residents with the					
	following conditions would be reviewed;					
	abnormal labs, kidney disease, and					
	diarrhea. The policy further indicated					
		be offered fluids during				
	_	ss, in the afternoon, and				
at bedtime. with the meal fluid intake						

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Facility ID: 000114

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155207		A. BUILDING B. WING STREET ADDRESS CITY STATE ZIR CODE					
NAME OF PROVIDER OR SUPPLIER NEW HAVEN CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCEO TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	being recorded on the meal fluid intake. Residents requiring intake and output monitoring would be placed on the intake and output monitoring record. The policy did not include how to determine who would be placed on this monitoring. This Federal tag relates to Complaint IN00114407 3.1-46(b)						

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Facility ID: 000114

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